

A POLITICAL ECONOMY
PERSPECTIVE ON
ACHIEVING
CONTRACEPTIVE SELF-
RELIANCE IN TURKEY

by

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October 2004

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Contents

Acknowledgments	iv
Abstract.....	v
Abbreviations	vi
Introduction to Turkey’s Family Planning Program Self-Reliance Initiative.....	1
A Political Economy Framework for Explaining Policy Change	3
Turkey’s Contraceptive Self-Reliance Strategy	6
Stakeholders for Contraceptive Self-Reliance in Turkey	6
Contextual Issues	9
Public Sector Budgeting	10
Targeting Strategy	14
Conclusions.....	19
References.....	21

Acknowledgments

Much of the information contained in this paper was obtained over the course of seven years of technical assistance provided by the authors during the United States Agency for International Development's (USAID) phaseout of population sector assistance to Turkey. The many others who worked alongside the authors as technical assistance advisors helped shape the knowledge and insights reflected herein. Ms. Sema Hosta and Dr. Fahreddin Tatar stand out as particularly important colleagues. The authors are also grateful to Dr. Rifat Kose, director of the Ministry of Health's Directorate for Maternal and Child Health and Family Planning (MCH-FP), who not only provided historical information for this paper but whose tireless efforts to sustain the strength and ensure the survival of the national MCH-FP program were an inspiration to all who worked with him during much of USAID's phaseout of support. A debt of thanks is also owed to the directors and MCH-FP program managers of provincial health departments who contributed information for this report and who form the backbone of the public sector's family planning program. Their ground-level view of the reproductive health of women and men in Turkey, which was at stake during phaseout, imbued the policy reform process with a rightful sense of urgency to act. Others who contributed over the years by way of their own efforts to secure the future of the program are too numerous to name, but they include POLICY's cooperating agency partners, KIDOG, academic leaders, other public sector leaders and civil servants from several sectors, and commercial sector partners, including representatives of pharmaceutical firms in Turkey and medical professionals.

Finally, the authors thank the reviewers of this study for their guidance, advice, patience, and support during the process of documenting the political aspects of the self-reliance process in Turkey. Denise Lionetti, Karen Hardee, and Carol Shepherd reviewed this document on behalf of the POLICY Project. Elizabeth Schoenecker, Rose McCullough, and Alan Bornbusch reviewed it on behalf of USAID/Washington. We would also like to thank Nancy McGirr for her expert editorial guidance. The views expressed in this document, however, do not necessarily reflect those of USAID.

Abstract

In 1994, after three decades of donor support to Turkey's national family program, the U.S. Agency for International Development (USAID) announced its intention to phase out assistance. On the eve of donor phaseout, Turkey's public sector program was serving nearly 60 percent of the market for modern family planning methods, including many nonpoor clients. During the transition period, the Ministry of Health was challenged not only to obtain new resources to replace donated contraceptive commodities but also to assume new technical responsibilities for the program. The story of how the ministry succeeded is often told in technical terms (e.g., number of procurements, budget trends, pilot project design, etc.). An equally important part of the story is the political and institutional context within which success was achieved. Examining how the MCH-FP Directorate overcame challenges to put in place a sustainable strategy for the public sector family planning program reveals the political dimensions of the process. Using a political economy framework, this paper examines the processes that led to implementation two central components of Turkey's national self-reliance strategy: obtaining annual budget allocations for contraceptives and targeting free services to the poor. The framework used here to analyze the process of formulating and adopting Turkey's contraceptive self-reliance strategy has five components: stakeholders' characteristics, institutional characteristics, contextual conditions, process characteristics, and reform characteristics.

Abbreviations

ANAP	Motherland Party
DSP	Democratic Left Party
FP	Family planning
GAP	Southeastern Anatolia Project
HSAF	Health and Social Aid Foundation
IMF	International Monetary Fund
IUD	Interuterine device
KIDOG	Turkish NGO Advocacy Network for Women
MCH	Maternal and child health
MHP	National Action Party
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Nongovernmental organization
RP	Refah Partisi (Welfare Party)
SPO	State Planning Organization
SSK	National social insurance organization
USAID	United States Agency for International Development

Introduction to Turkey's Family Planning Program Self-Reliance Initiative

In 1994, after three decades of donor support to Turkey's national family program, the U.S. Agency for International Development (USAID) as the main donor announced its intention to phase out assistance.¹ In those 30 years, the Ministry of Health (MOH) had built a strong national program, and contraceptive prevalence rose to 63 percent and total fertility declined to 2.7 children per woman by 1993 (MOH et al., 1994). By that time, the program had put in place solid public and private sector components; however, with the public sector component almost completely reliant on donated contraceptive commodities, USAID's announcement challenged the sustainability of that component.

On the eve of donor assistance phaseout, Turkey's public sector program was serving nearly 60 percent of the market for modern family planning methods. Public healthcare facilities provided free family planning services, including contraceptive commodities, to all who sought them, regardless of ability to pay. Consequently, the public sector was the major provider of family planning services to the nonpoor as well as to the poor, including half of all social insurance beneficiaries.² The MOH had sufficient service delivery capacity to serve this large family planning market share, but, when donors began to withdraw support, the institutional structures, program policies, and the government's commitment to mobilizing national resources to purchase contraceptive supplies were untested.

In 1994, the Turkish Minister of Health and USAID signed a memorandum of understanding (MOU) calling for an incremental phaseout of USAID-donated contraceptives over a five-year period between 1996 and 2000 (POLICY Project, 1999a). At least on paper, the transition schedule to national self-reliance appeared straightforward. During the period, the MOH was challenged not only to mobilize an estimated US\$4 million per year to replace donated contraceptive commodities but also to assume responsibility for the technical tasks of forecasting commodity and budget requirements and procuring the commodities (Baser et al., 2002).

Augmenting existing technical skills was a relatively straightforward aspect of the challenge, but it was complicated by the following factors:

- low awareness about the phaseout beyond the MOH's Maternal and Child Health-Family Planning (MCH-FP) Directorate, in which the responsibility for responding to the phaseout was concentrated;
- philosophic underpinnings of the program that promoted broad, egalitarian access to free services; and
- situational factors beyond the control of the MCH-FP Directorate, such as public sector budget austerity, conservative political forces, and frequent changes in national political leadership.

The story of how the MOH succeeded in mobilizing resources is often told in technical terms by chronicling the analyses conducted to forecast commodity and budget needs, recounting outcomes of

¹ The Turkey National Family Planning Program was formally launched in 1965 with the adoption of *Population Planning Law #557*, which legalized the sale and distribution of contraceptives, legalized voluntary surgical contraception, and allowed some dissemination of public information on family planning.

² Employees of private sector firms are beneficiaries of the national social insurance organization (known by its Turkish acronym SSK), which provides health insurance. However, lacking resources and the necessary infrastructure for family planning services, SSK meets the family planning needs of only about 10 percent of its beneficiaries.

budget processes, and summarizing policy changes. Such a technical approach portrays a simple, linear progression from donor dependence to self-reliance. A larger and equally important part of that story remains untold—that is, the political and institutional context within which the MOH achieved success and how the efforts of important stakeholders facilitated and sometimes hindered progress toward the goal of national contraceptive self-reliance. Turkey’s ultimate goal was to transition away from donor support while protecting three decades of program gains. Examining how the MCH-FP Directorate overcame challenges to put in place a sustainable strategy for the public sector family planning program reveals the political dimensions of the process. Using a political economy framework, this paper examines those political aspects of the processes that led to the implementation of two central components of Turkey’s national self-reliance strategy: (1) obtaining annual budget allocations for contraceptives, and (2) targeting free services to the poor while requesting that nonpoor clients pay voluntary donations for their contraceptive commodities.³

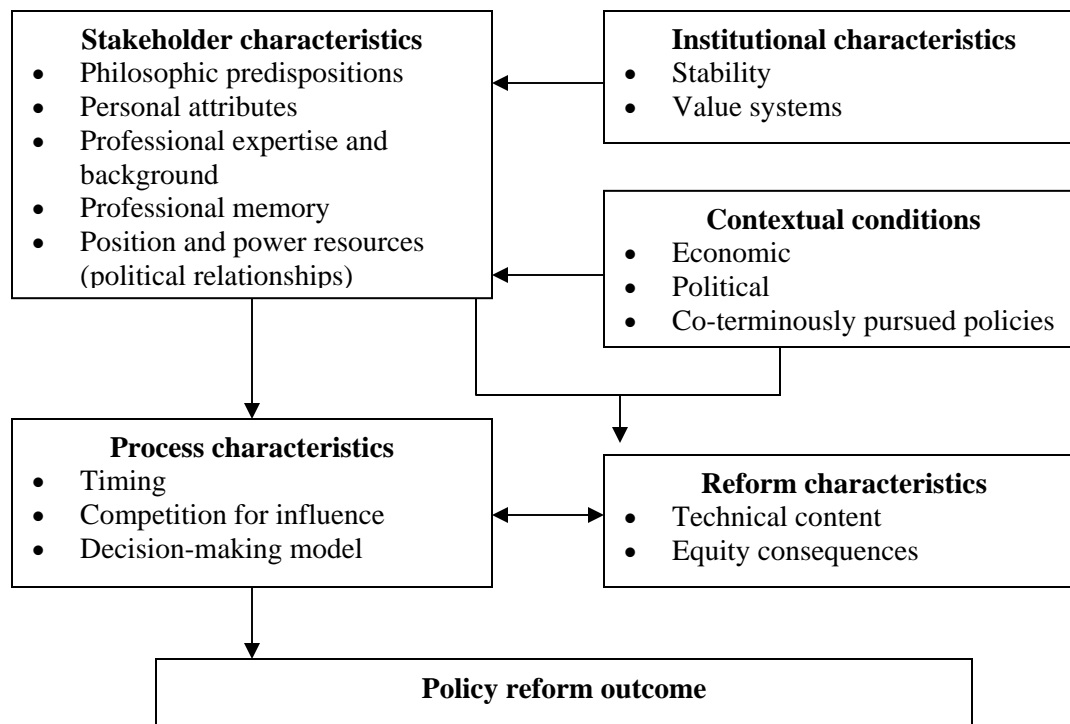
³ The information and analyses presented in this paper are derived from first-hand observations obtained during seven years of technical assistance provided by staff of the Futures Group’s POLICY Project.

A Political Economy Framework for Explaining Policy Change

Recognition of the limitations of technical descriptions to explain why some health policy reform efforts succeed and others fail spurred Grindle and Thomas (1991) to explore political and organizational dimensions of health policy reform processes. They describe the “ambiguous nature of reform” and state that “reform is inherently conflictual because it imposes costs on some and provides benefits in terms of favorable policy on others.” They propose a framework to identify such ambiguities so that change processes can be better understood. Their framework components are largely structural, focusing on characteristics of stakeholders involved in or affected by the change process, structures and norms of the institutions represented by those individuals, and constraints and opportunities arising from the broader institutional environment. Reich (1995) proposed a framework that adds process elements, including how alliances are formed, how negotiations are influenced by some of Grindle and Thomas’s structural elements, and how both influence the policy reform process outcome. The framework used here to analyze the process of formulating and adopting Turkey’s contraceptive self-reliance strategy combines Grindle and Thomas’ and Reich’s frameworks and has the following five components (see Figure 1): stakeholders’ characteristics, institutional characteristics, contextual conditions, process characteristics, and reform characteristics.

Each component directly or indirectly influences the reform process, which in turn determines the outcome of the process. This section briefly describes each component and provides an overview of the principal stakeholders in Turkey, their institutions, and major contextual issues.

Figure 1. Framework for Analysis of the Political Economy of Reform



Overview of the Framework

Stakeholder characteristics: Stakeholders are the central driving force of any policy reform process. Grindle and Thomas describe five important characteristics that shape stakeholders' perceptions of the policy issue around which reform is centered and the stakeholders' problem-solving behavior. These characteristics are shown in Figure 1. Each individual operates with his/her own *philosophic predisposition* with respect to how decisions should be made and is positioned somewhere along a continuum between democratic participation and technocratic decisionmaking. *Personal attributes*—such as each stakeholder's propensity for risk taking, consensus seeking, and demonstrating aggressiveness in confronting issues—also play an important role. *Professional expertise* influences the lens through which issues and information are viewed and the language of debate that is adopted. Career bureaucrats in the MOH, for example, perceived Turkey's family planning self-reliance challenge differently than medically trained provincial health leaders. These differences influenced what was considered relevant, whose views were sought, and who was engaged in dialogue and planning. *Professional memory* about past reform efforts, including what worked and did not work and what behavior was rewarded or sanctioned, affects perceptions about prospects for current reform, thereby influencing decisions about what role to take in subsequent reform processes. In the case of Turkey's shift to contraceptive self-reliance, some stakeholders' behavior during the phaseout process was influenced by their experience with a previous phaseout threat a decade earlier. Finally, stakeholders' *position and power resources* refer to their organizational position and political and institutional commitments and loyalties which influence not only their willingness but also their ability to participate in decisionmaking and reform processes. Stakeholders' positions and behaviors are also influenced by the institutions in which they serve and by contextual factors and conditions, which, in turn, flavor the characteristics of the reforms.

Institutional characteristics: *Stability* refers to the potential disruptiveness of proposed reforms as they affect the institution and the institution's connectedness with ongoing political struggles. In Turkey, targeting required substantial effort to orient the government's expansive service delivery network to a new way of handling family planning clients, new systems for managing revenue from client donations, the revision of information systems, and the creation of new institutional links. These changes were viewed as substantial and potentially disruptive to the status quo. With respect to ongoing political struggles, government institutions were grappling with the greater social struggle between the secular foundations of the modern Turkish state and the gathering strength of nationalists and political Islamists.

An institutional *value system* refers to the philosophic foundation of the decisionmaking processes, which, taken alone, does not account for the political hazards of reform processes. Reich describes the utilitarian state in which decisions are technocratic, maximize human welfare, protect equity, and increase efficiency. The communitarian state also places emphasis on the common good but takes account of political realities, incorporating negotiation and compromise as decisionmaking tools. In reality, most countries incorporate both technocratic and political negotiation in reform processes and decisionmaking. In Turkey, government institutions have historically placed more emphasis on the political, rather than technocratic, aspects in decisionmaking.

Contextual conditions: *Economic and political conditions* in the broader environment can have a profound impact on reform processes and prospects and influence stakeholders' views. In Turkey, poor fiscal policy and the consequent public sector budget austerity conditions influenced efforts to achieve greater budget support for contraceptive commodities. Similarly, the resurgence of conservative political parties gave strength to opponents of the national family planning program, creating a potentially formidable source of opposition to reforms required to secure family planning program self-reliance. *Co-terminously pursued policies* refer to other policies that could either help or hinder efforts to secure support for the reforms of interest. In Turkey, for instance, a national policy targeting the southeastern

region for development, which included family planning services, provided an opportunity to secure support for both greater budget support and targeting.

Contextual conditions can directly influence reform characteristics by way of precipitating events, as in the case of donor phaseout for contraceptive supplies. Many considered Turkey as socioeconomically beyond the stage where donor support for the national family planning program should be necessary. Contextual conditions also mediate process and reform characteristics through stakeholders by influencing their perceptions about processes and reforms that are and are not feasible.

Process characteristics: Reich lists three dimensions of reform processes that influence outcomes: *timing*, *competition for influence*, and the prevailing *decisionmaking model*. Timing refers to the point at which a reform process is initiated (e.g., best at the beginning of a leadership change) and whether an all-at-once or an incremental approach to change is being sought. Process demands for all-at-once changes are more intensive, leaving policymakers less room to mobilize support and negotiate with opponents. Turkey sought budget reforms all at once but took an incremental approach to instituting the targeting reforms. Reich also speaks about exploiting times of crisis to promote change, an issue relevant to the self-reliance case in Turkey. Turkey made some of its greatest strides in developing its self-reliance strategy during times of crisis and immediately after leadership changes.

Competition for influence is a process element that relates to internal and external support of and resistance to the reform. The outcome of the process is a function of how well support and especially resistance are predicted, how supporters and opponents are appealed to, and how effectively presumed beneficiaries of the reform (e.g., women parliamentarians in Turkey) are organized.

Reich describes several decisionmaking models and, as with institutional value systems, provides evidence that more than one model may be at work in a given reform process. It is the extent to which one model or another is dominant that affects the process outcome. The political will model embodies a technocratic approach, whereby decisions by political leaders drive the change process. In the political faction's model, decisionmakers seek information about the needs and wishes of different social groups and attempt to make decisions that meld such information with their philosophic principles. The political survival model views decisionmakers as opportunists who assess policy choices from the perspective of how they can affect their power base and survival.

Reform characteristics: Stakeholders influence what is brought forward in the way of reform proposals. Characteristics of the proposed reforms in turn influence the decisionmaking process, including what sectors and organizations need to be involved (e.g., the Ministry of Finance would need to participate in reforms that include a public budget component), what decisions need to be made, and who will be interested in the ultimate decisions. Interest, from both supporting and opposing perspectives, is affected by what Reich refers to as distributional consequences of the reform. In the case of targeting, representatives of groups that are likely to lose or be passed over may become a source of opposition to the reforms. Those likely to benefit from the reforms in terms of power and influence are probable sources of support.

Reform characteristics influence process characteristics in that different reforms require action by different types of stakeholders while the implementation of some reforms requires greater or lesser effort. Process characteristics also influence reform characteristics in two ways. First, the realm of process feasibility influences the types of reforms that can be moved forward and therefore those that are launched into the process. Second, the process itself produces iterative changes to the reform, altering it from its shape as originally introduced.

Turkey's Contraceptive Self-Reliance Strategy

Turkey's contraceptive self-reliance strategy had two components: public budget support for contraceptive purchases and targeting. A common group of stakeholders was involved in processes leading to the development of both components, and the processes unfolded in the same set of contextual conditions. This section briefly introduces the stakeholders and contextual conditions; other sections describe dimensions specific to budgeting and targeting.

Stakeholders for Contraceptive Self-Reliance in Turkey

At one end of the spectrum, leaders in the MCH-FP Directorate were the primary stakeholders, responsible both for operating the national family planning program and crafting a response to the phaseout of donor assistance to the program (Baser et al., 2002). At the other end of the spectrum, the principal targets of the reform process were decisionmakers in the Ministry of Finance (MOF) who controlled access to public budget funds. The minister of health had ultimate authority to approve strategies and played a key arbiter role between the MCH-FP Directorate and the MOF and other government agencies. The Health and Social Aid Foundation (HSAF) became an important stakeholder in building and implementing the targeting component of the self-reliance strategy.⁴ Many other organizations played an intermediary role, supporting the MCH-FP Directorate in its efforts to win the support and resources it needed to compensate for the loss of donor support (POLICY Project, 1999). Table 1 summarizes the principal stakeholders.

Table 1. Stakeholders' Organizations and Their Roles in Turkey's Contraceptive Self-Reliance Strategy Development Process

Primary role to lead process and shape solutions	Supportive or intermediary role	Targets for action and decisions and implementation
MCH-FP General Directorate (Ministry of Health)	State Planning Organization KIDOG ⁵ Academicians Primary Health Care General Directorates (MOH) ⁶ Provincial Health Officers Healthcare providers Family planning clients Women parliamentarians Health and Social Welfare Committee of Parliament Minister of Health HSAF	Ministry of Finance Women parliamentarians Health and Social Welfare Committee of Parliament Minister of Health HSAF

⁴ HSAF is a nongovernmental organization (NGO) established to encourage the development and provision of high-quality services at public sector health facilities. The foundation raises funds by collecting donations from clients at these facilities, with most of the revenue retained at the facilities where it is collected.

⁵ The Turkish NGO Advocacy Network for Women.

⁶ The MOH is organized into General Directorates, such as the MCH-FP General Directorate (hereafter referred to as the MCH-FP Directorate, which manages the national family planning program, and the Primary Health Care General Directorate, which manages most of the public sector's service delivery facilities and personnel.

MCH-FP Directorate Leadership

During the seven-year phaseout, three senior professionals in the MOH's MCH-FP Directorate played prominent roles in the policy reform process: the deputy director and the two directors who held office during the transition period. Three other deputy directors and a group of senior family planning technical experts supported the three senior professionals. While all the various professionals contributed to policy reform, the discussion here focuses on the three senior leaders and examines their professional background, power relationships, and individual attributes with respect to their actions and the processes by which they achieved increased public budget support and instituted a targeting strategy. The discussion also provides a brief analysis of the supporting stakeholder groups.

The deputy director was a career bureaucrat of long tenure, rising to the highest nonpolitical level possible.⁷ With considerable knowledge accumulated over nearly three decades in service to the family planning program, he exhibited considerable pride in and strong ownership of the program and was an important and consistent source of influence in program decisions. In the tumultuous political environment of the 1990s, the minister of health changed once a year on average and while the director was always subject to replacement upon changes in the minister's office, the deputy director was not. The deputy director survived several leadership changes in large part by adopting a conservative stance to program management. He shouldered much of the responsibility for protecting the national family planning program from potential detractors and embraced a strategy of keeping the program out of the political light. He also adhered closely to the norms of Turkish government institutions, which promoted reactive rather than proactive approaches to problem solving and discouraged challenges to the status quo. Such a problem-solving approach had succeeded in the past, with little perceived value in changing approaches.

At the outset of the transition period to contraceptive self-reliance, the deputy director apparently perceived that the risks of advocating for changes to secure the program's future would outweigh the benefits. In the absence of strong support, much of the responsibility for as well as the risks of proposing change would accrue to the deputy director. Moreover, a rise in the power of conservative political factions became an important perceived risk factor that militated against policy action that might increase program visibility. The perceived concentration and balance of risks then changed over time, as discussed below.

During the phaseout period, two individuals served as national program director. Unlike the deputy director, neither was a career bureaucrat, a distinction that contributed significantly to differences in approach to responding to the challenge of contraceptive self-reliance. The program director for the first three years was a respected demographer seconded from an academic institution. Her leadership style endowed the deputy director with a large degree of independence in program management. Her approach to the challenge of donor assistance phaseout may be described as opportunistic; she took advantage of fortuitous circumstances, an approach that fit well with the prevailing institutional norm of reactivity. The lines of communication between the MCH-FP Directorate and the minister's office, however, were not well developed, limiting opportunities for high-profile advocacy and action. Moreover, though the phaseout was well underway by the end of the program director's tenure, there was no sense of urgency as contraceptive stock levels in national warehouses were robust.

Following a change in national political leadership, a new program director was appointed to lead the MCH-FP Directorate in 1998. That director was a public health professional from one of the most dynamic provincial health departments in the country, and his provincial-level experience provided him with a pragmatic perspective on the contraceptive self-reliance challenge. He was willing to adopt high-

⁷ Program directors are in large part chosen by politically appointed ministers.

risk strategies to protect the integrity of the national program. Good relationships with senior staff in the minister's office gave him ready access to the power and support necessary to approach other institutions, such as the MOF and HSAF, in pursuit of solutions.

Moreover, soon after the program director assumed his position, contraceptive commodity stock levels in warehouses began to deteriorate. With mounting concern about the public health implications of deteriorating stocks, he refused to countenance a waning program during his watch. Willing to play the maverick, he drew on his background as a provincial health leader and on his knowledge of the MOH infrastructure to override the institutional predisposition to reactivity and thus move the process forward.

Supporting Stakeholders

Some stakeholders, such as the State Planning Organization (SPO), played the role of broker among stakeholders and of facilitator both at formal policy dialogue sessions and behind the scenes. The top leaders of the SPO were among the strongest supporters of the MCH-FP Directorate's efforts to force contraceptive self-reliance onto policy agendas at the highest levels of the MOH, MOF, and HSAF. Specifically, the SPO's health section leader was motivated largely by a sense of professional duty and an appreciation of the role of policy dialogue intermediary.

Members of the Turkish NGO Advocacy Network for Women (KIDOG), although entering late into the change process, also played an important and supportive role by influencing stakeholders that the MCH-FP Directorate was statutorily prevented from reaching (Cardenas and Richiedei, 2000). While KIDOG's strategy contained elements of a watchdog role over the MOH, to a greater extent the strategy played out as an advocacy role in support of the MCH-FP Directorate proposals for policy change and budget support. KIDOG members active in the process included those with intricate knowledge of government budget structures and processes as well as the politically well-connected. Their political connections allowed KIDOG to reach influential parliamentarians and government executive leaders whose support helped turn the tide in favor of the MCH-FP Directorate's proposed solutions to the phaseout of donor support for the family planning program.

The second MCH-FP director effectively tapped support from directors of other departments, exerting pressure on the system to adopt proactive solutions to the phaseout challenge. Understandably, the department directors lent support according to their own policy and budgetary self-interests. For instance, on the one hand, while the MCH-FP Directorate oversaw program policy, coordination, and contraceptive supplies, the Primary Care Department was responsible for delivery of most public sector family planning services. Support for solutions proposed by the MCH-FP Directorate was necessary for continuation of these services. On the other hand, access to MOH emergency funds (see next section) to meet the pressing needs of other departments would be reduced as long as the MCH-FP Directorate was tapping those funds to alleviate shortages resulting from inadequate funds within the MCH-FP Directorate's budget to purchase contraceptives.

Additional stakeholders played integral roles. Academicians, mainly from Hacettepe University, provided technical guidance in assessing strategic options and in the course of policy dialogue sessions. Provincial health directors were instrumental in both refining operational aspects of targeting and implementing that component of the strategy. Commercial pharmaceutical importers not only participated in formal policy dialogue forums but also became the source of the contraceptive supplies needed to keep the public sector's family planning services operational. In addition, the commercial sector increased its participation in the family planning market by serving clients who chose not to seek public services under the terms of the MOH's new targeting strategy.

Two other stakeholder groups, leaders in the MOF and HSAF, played important roles in the process of defining national contraceptive self-reliance strategies. Their respective roles were largely specific to processes related to either obtaining budget support or targeting and are therefore examined in the next section.

Contextual Issues

Three contextual issues played a central role in the self-reliance reform process in Turkey and, as such, require specific description. These factors were for the most part outside the direct control of the principal stakeholders in the change process, but they exerted strong influence on stakeholder decisions about when and how to act.

The Donor's Resolve

Turkey's history of donor phaseout actions has a context of its own. About a decade before initiation of the 1990s phaseout period, USAID initiated another phaseout planning process. However, because of concerns that Turkey was not yet ready to assume full responsibility for financing its national family planning program and could potentially face severe health consequences if the government did not respond successfully, USAID never launched the phaseout. In view of the aborted phaseout, program leaders were hopeful that USAID might decide against the current phaseout as well. Whether early inaction on the Turkish government's part was intended to give the donor reason to yet again question the wisdom of proceeding with the phaseout or was merely indicative of the absence of a sense of national urgency, the effect was the same: restrained efforts as phaseout began.⁸

The phaseout plan itself and the donor's actions early in the transition period gave MCH-FP program managers cause for questioning the donor's intentions. The plan called for maintenance of full supplies for IUDs during the first four of the five phaseout years and only a gradual reduction in oral contraceptive and condom supplies—20 percent per year—from the start. With an ample cushion stock of each method—at least 15-months' supply—at the start of phaseout, at least two years would have to elapse before stocks dropped to a level that might trigger a sense of crisis (POLICY Project, 1997a). With no immediate threat to the program, the donor's gradual approach to phaseout would likely not elicit an early response. Moreover, during the first year of the phaseout, the donor did not reduce its donation levels according to the plan, fueling skepticism on the part of the MCH-FP program managers about the donor's resolve. Given the environment and the perceived risks of increasing program visibility and challenging the status quo, the program managers' initial decision not to change policies regarding budgeting and service delivery may be interpreted as rational.

Austerity in the Public Budget Environment

An austere fiscal environment characterized the entire transition period such that the government strictly discouraged proposals for “new” spending by its agencies. Agencies largely based their budgets on the previous year's allocation, adjusted for inflation and little more. In this environment, budget allocations fell short of covering even existing recurrent budget requirements, and creative mechanisms evolved to augment budgets. At the outset of the transition period, MCH-FP program managers assumed that

⁸ Confusion about the start date for the phaseout probably also contributed to the initial restraint by government agencies. The MCH-FP Directorate assumed the timeline to reflect calendar years (1995–1999), which is consistent with its fiscal year system. In explaining why full supplies were delivered by USAID in calendar year 1995, however, USAID noted that its fiscal year 1995 (which began in October 1994) cutbacks would not be experienced by the program until Turkey's 1996 (calendar) program year.

requests for increased budget support to compensate for the phaseout of donor assistance would be interpreted as a request for a new program need and therefore would be denied. Rather than face what was perceived as a certain denial, agencies did not issue requests. In the context of uncertainty about the donor's resolve to follow through with the phaseout, MCH-FP Directorate leaders had even less incentive to challenge the strict rules governing annual budget requests.

Conservative Political Forces

Throughout the phaseout period, religious-based politics and pronatalist nationalism were on the rise in Turkey. From 1995 to 1997, the Islamist-based Welfare Party (RP–Refah Partisi) led a coalition government. In 1997, after two years of increasing public confrontation about the role of religion both in Turkish society and government policies, the Turkish Constitutional Court ordered the RP dissolved on the grounds that it was undermining the secular precepts of government. In addition, the court banned the RP's top leaders from holding political office for five years. Two short-lived caretaker governments followed in 1998 (led by the Motherland Party—ANAP) and in 1999 (led by the Democratic Left Party—DSP). A new coalition government took office after general elections in 2000. Though led by the left-leaning DSP, the government shared power with the right-wing National Action Party (MHP), the Islam-Based Virtue Party, and the conservative Motherland Party (Europa World Year Book, 2002).

The rise to power by the Islamic-based parties fostered a climate of caution on the part of national MCH-FP program leaders. Conservative political factions tended toward a social agenda that was perceived as unsupportive of family planning. Political nationalism also favored a conservative agenda. The more secularly oriented national family planning program leaders sensed that nationalists' opposition to family planning was grounded in the belief that a large population would enhance the power of the Turkish nation and that outsiders were promoting family planning as a means of limiting Turkey's global role and influence. Therefore, the prevailing belief by family planning program leaders and advocates held that survival of the program largely depended on its low visibility. The gathering strength of conservative forces meant that vocal, visible efforts to initiate policy change processes and to secure the future of the family planning program would have attracted potentially destructive attention from undesirable political quarters. However, the ascension of the DSP, although in coalition with these conservative partners, eased some concerns about the consequences of advocating for the family planning program's new needs.

Public Sector Budgeting

Even before the official start of the phaseout period, USAID and other donors tried to get the matter placed on the health sector's policy agenda. At issue was the cost to the government of replacing USAID contraceptive commodities. In 1994, MCH-FP Directorate leaders sought an independent assessment of the year-by-year budget needs for contraceptive procurement during the five-year phaseout. The analysis estimated that annual costs would total US\$4 million when the MCH-FP Directorate assumed full responsibility for financing its contraceptive supply needs (POLICY Project, 1999a). Despite the information yielded by the analysis, the MCH-FP Directorate failed to request budget funds to cover the costs incurred during the phaseout's first two years. Clearly, a lack of strategic vision does not explain inaction on the budget front. From the beginning, senior MCH-FP Directorate officials maintained that their goal was to maintain the public sector program in its full capacity and structure and that their principal strategy for achieving that goal was to obtain annual budget allocations in the full amount necessary to purchase the required contraceptive commodities.

Evolution of Stakeholders' Positions on Public Budget Funding for Contraceptives

As noted earlier, during the phaseout's first two years, the deputy director of the MCH-FP Directorate steered a steady and cautious course through negotiations for the annual budget, avoiding controversy and reducing perceived political risks inherent in the budget process. A chief concern among family planning leaders was the perceived opposition to family planning services among conservative political forces. Though well aware of the risks to the program of failing to obtain additional budget resources even amid the slow and inconsistent implementation of donor phaseout, family planning leaders perceived the risks of inaction with respect to the budgetary component of the strategy to be lower than the risks of drawing attention to the program itself in an increasingly unfavorable political environment.

The first break came in 1997, the second year of the transition period, when the MCH-FP Directorate's budget allocation unexpectedly included a US\$500,000 increase in the consumable supplies line item. Although the MCH-FP Directorate had not requested additional funds for contraceptives, the director and the deputy director chose to designate those funds for a trial procurement of contraceptives. Risks to spending the already allocated funds for contraceptives were low. In fact, a successful procurement could unobtrusively set a precedent within government circles and send a signal to USAID that the MOH was taking serious steps to implement the phaseout MOU. Given that MCH-FP Directorate warehouse stocks were still healthy and that no sense of urgency had yet emerged, program leaders considered any higher-profile action unnecessary.

In 1997, USAID budget issues precipitated a decision to hasten the pace of the phaseout. USAID announced that it would not meet its agreed-upon allocation of condoms at 60 percent of the MCH-FP Directorate's annual need for that year but instead would deliver only about 40 percent (POLICY Project, 1998). Furthermore, USAID announced that condom donations would cease altogether the next year. The pace of the phaseout and the failure of the MCH-FP Directorate's trial procurement in part prompted a crisis in condom supplies.⁹ In addition, with USAID donations for oral contraceptives now down to 60 percent of need and the MCH-FP Directorate's unsuccessful attempts to purchase supplies sufficient to make up the shortfall, national warehouse stock levels of oral contraceptives were also dropping at an alarming rate.

By the start of 1998, condom stocks had dwindled to a one-month supply while oral contraceptive stocks had dwindled to a 10-month as opposed to a 15-month supply, which is considered a safe supply. Moreover, the government did not allocate any new funds to the MCH-FP Directorate budget for contraceptives in 1998. The supply constraints soon began to affect product availability at MOH healthcare facilities. Suddenly, the nascent challenge posed by donor phaseout became a tangible crisis. In the institutional environment of Turkish public agencies, the transformed nature of the crisis changed the balance of program versus political risks, reducing the reluctance among MCH-FP Directorate leaders to engage in higher-profile policy advocacy.

The change in MCH-FP Directorate leadership occurred almost simultaneously with the change in the status of contraceptive supplies. Three years into the phaseout period, the new MCH-FP director assumed an active role in the budget process, thereby bringing about a change in the concentration of responsibility for budget development and negotiation. The result was a commensurate diffusion of the balance of risks and, for the first time, initiation of higher-profile action in the following year. In particular, budget analysis information provided a basis for requesting contraceptive procurement funds in the MCH-FP Directorate's annual budget. Yet, even then, policy discussions within the MCH-FP Directorate reflected

⁹ The trial procurement failed, with the funds returned to the central treasury in large part because the trial was initiated late in the year such that the bidding process could not be completed before the fiscal year deadline for closing government procurement contracts.

concerns about the wisdom of seeking to establish a new line item dedicated to contraceptive commodities and thus raising program visibility. Creating a new line item would require higher-profile action as opposed to merely requesting an increase in the existing line item for consumable supplies.

One of the new director's first actions was to bring the issue to the minister's attention and put it on the agenda for a multipronged solution. In the short term, he convinced the minister to use emergency funds to procure contraceptives in sufficient quantity to stave off stock-outs at the service delivery level. Conceding that low contraceptive stocks constituted a health emergency, the minister placed the issue of contraceptive funding on the MOH's policy agenda. For the first time, the minister had defined contraceptive supplies as an ongoing program need.¹⁰ Tapping the emergency fund also had the effect of increasing support for annual, on-budget allocation as competition for access to those funds was strong among the MOH's general directorates and rules prevented the fund from providing emergency relief year after year.

The director's longer-term approach called for garnering broader support within the MOH and seeking partnerships with an external advocacy organization to reach influential legislative leaders. Within the MOH, he obtained support from service delivery departments by repositioning the contraceptive supply issue as an important program issue rather than simply as an administrative issue. While the MCH-FP department is chiefly responsible for national program support, including training and commodities among other aspects, the primary care, preventive care, and hospital departments are chiefly responsible for service delivery. Recognizing that the competition for MOH emergency funds was strong, the director also made his success at tapping those funds widely known, giving other MOH directors a vested interest in supporting on-budget allocations for contraceptives so as to eliminate the need to use emergency funds.

The Role of Strategic Partnerships

The director also pursued a strategy to increase support among other government agencies for a contraceptive budget allocation. For example, he made effective use of long-standing support from the health liaison at the State Planning Organization (SPO), as illustrated by his efforts to link program needs with a priority government development initiative for the impoverished southeastern provinces—GAP, or the Southeastern Anatolia Project. The GAP initiative was an important element of the government's policy agenda, aimed at both reducing long-standing disparities between the southeast and the rest of Turkey and improving external relations, thereby strengthening its bid for European Union membership.

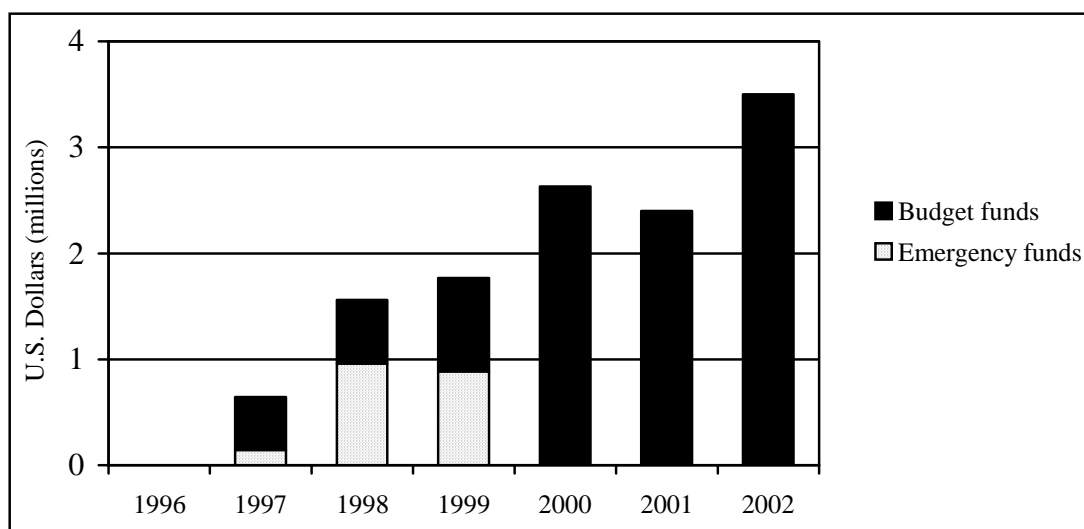
GAP listed family planning as one of several critical services that were to be provided free to all residents in the southeastern provinces. The SPO argued that funds would have to be allocated to the MCH-FP program to purchase contraceptives if they were to be made available through the public sector's health system in the southeastern region. It was apparent that at least one government agency other than the MOH (the SPO) considered family planning services—and the contraceptives that were distributed through the public health system—an ongoing, basic element of public services. Tying the contraceptive budget request to the government's important GAP policy initiative strengthened the MCH-FP's case.

The most strategic external partnership nurtured by the director involved an NGO network, KIDOG. The director provided the network with current information on contraceptive stocks, MCH-FP Directorate spending, and budget needs. KIDOG members, in turn, used their high-level political connections to advocate among women parliamentarians and Parliament's Health and Social Welfare Committee. KIDOG members even sought and obtained an audience with the president, bringing the budget needs for contraceptives to the highest political level (POLICY Project, 1999a). The support of parliamentarians

¹⁰ Previous MOH leaders defined contraceptive supplies as a new program function; under budgeting rules prevailing during a period of public budget austerity, new program functions were not eligible for funding.

and the president was a critical component of the budget strategy, alleviating concerns about the political risks of increasing the family planning program's visibility among Turkey's more conservative factions. By allaying political concerns and garnering broad support from the highest administrative levels in the MOH, the MCH-FP Directorate prevailed in budget negotiations with the MOF, even overcoming the MOF's strict rules on funding "new" program needs. Figure 2 shows the trend in sources and levels of budget allocations for contraceptive supplies during the phaseout.

Figure 2. Government of Turkey Allocations for Contraceptive Commodities



Source: Baser et al., 2002

Summary of the Public Budget Policy Reform Component

In summary, a combination of fortuitous events and expansion of the family planning advocacy network brought about the attainment of increased budget support for Turkey's family planning program. A proactive director assumed responsibility for the national program just as contraceptive stock levels evidenced a sharp downturn—partly in response to the donor's decision to accelerate phaseout. In addition, the almost simultaneous change in government brought to power a more secularly oriented administration and, with it, a new minister of health who built a constructive working relationship with the MCH-FP program. By immediately and thoroughly orienting himself to the situation, the new minister was prepared to take advantage of these opportunities quickly. For example, the large-scale GAP initiative, in which family planning was defined as a basic government service to be provided to residents of southeastern provinces, gave the MCH-FP Directorate the additional support it needed to change the MOF's perception of contraceptive supplies from a new to an ongoing program need.

Expanding the network of support for a budget allocation for contraceptives served two purposes. First and foremost, it made it more difficult for stewards of the public budget to resist the MCH-FP's efforts to secure budget support, even in the face of stringent austerity rules and regulations. Second, expanded support diffused responsibility for budget advocacy and negotiation. More important, the diffusion of responsibility reduced concern about potential adverse consequences for advocacy stands that ran contrary to the status quo in a climate of fiscal restraint. It relieved an important source of reluctance on the part of some national program leaders, encouraging them to take a more proactive stand in tandem with their supporters.

Although budget policy efforts were in large measure successful, allocations never reached the US\$4 million level estimated at the beginning of the period. As discussed in the next section, the MCH-FP Directorate's strategy was adopted in 2001 to close the gap.

Targeting Strategy

The option of targeting the distribution of publicly provided contraceptive commodities to a subset of vulnerable public sector clients first emerged in the public arena in 1997 after evidence from a market segmentation analysis showed that a substantial proportion of public sector clients were able to pay for products and services that were widely available in the private sector (Cakir and Sine, 1997). Targeting garnered little support at that time, principally because stakeholders in the MCH-FP Directorate, including senior leaders, deputy directors, and family planning experts, continued to espouse the directorate's chief policy objective as the maintenance of public sector services in the same quantity and structure as immediately before initiation of the phaseout period. As budget negotiations failed to yield sufficient resources to replace donated commodities and contraceptive stock levels fell to unprecedented levels, however, recognition of the potential value of targeting as a component of the self-reliance strategy increased. As was the case with the public budget issue, timing was an important factor in the appeal of targeting as a strategy. The contraceptive stock crisis in late 1997 and the change in MCH-FP General Directorate leadership were turning points in efforts to adopt targeting as a second pillar of the national self-reliance strategy. Compared to the budget dialogue process, the process following the 1997 introduction of the targeting concept involved a more complex array of institutions and individuals.

Evolution of Stakeholders' Positions on a New Targeting Strategy

Among most stakeholders, the idea of restricting access to services ran counter to prevailing views about the role and responsibility of the public sector in health service provision. Clauses in the national constitution, as well as weak trust in the commercial sector, contributed to the resistance. Consensus held that targeting would violate constitutional and legislative law. Debate centered on Article 41 of the constitution: *"The State shall take necessary measures and establish the necessary organization to ensure peace and welfare of the family, especially the protection of the mother and children for family planning education and application."* Top leaders and technical experts alike from the MCH-FP Directorate as well as stakeholders from the SPO, academia, NGO community, and healthcare providers interpreted the word "ensure" as mandating the provision of public family planning services to all, without differentiation according to ability to pay or any other characteristic. Furthermore, consensus held that charging public sector clients was not legal, thus ruling out targeting by instituting charges to nonpoor clients (POLICY Project, 1997b).

Primary and intermediary stakeholder resistance to the concept of targeting was as much a political stance as a philosophic one; yet, behind the scenes, leaders in the MCH-FP Directorate began to realize that as long as public budget funds were not meeting contraceptive procurement needs, some form of targeting was unavoidable to preserve the program and avoid de facto rationing. The MCH-FP director appointed in 1998 determined that, even under the most optimistic budget scenario, a gap would remain. Therefore, he sought to reconcile the objective of protecting the traditionally unrestricted access to public sector family planning services with resource realities.

By mid-1998, the MCH-FP director, deputies, and technical experts analyzed seven possible targeting options—some based on geographic location, others on contraceptive method, type of healthcare facility, and client health insurance status—and weighed the advantages and disadvantages of each in view of budget implications and potential population impacts. Although each approach was initially met with rejection, the amassed information heightened awareness about the inevitability of rationing and eroded

resistance to the notion of targeting. The MCH-FP Directorate was thus positioned to broaden dialogue on targeting with other directorates within the MOH and other intermediary stakeholders.

The MCH-FP director played a “policy champion” role, keeping the minister of health and directors from the Primary and Secondary Care directorates abreast of the contraceptive budget and supply situation and advocating for a targeting approach that would include a client cost-sharing component. The director engaged in one-on-one meetings with MOH colleagues and supported multisectoral policy forums. Multisectoral dialogue was an important aspect of increasing participation in decisionmaking among stakeholders, thus building consensus for policy reform. For the first time, the director included representatives from key provincial health departments in policy dialogue, expanding the base of support among public health professionals who were much closer to the service delivery level at which policy reform would be implemented. These provincial public health officials were more inclined to support innovative approaches to meeting the self-reliance challenge, counteracting administrative reluctance among national policymakers. Continuing through 1999, leaders from other government agencies, such as the SPO, the ministries of Finance, Education, and Women’s Affairs, leading academic institutions, the Turkish Medical Association, commercial pharmaceutical companies, and NGOs, participated in forums to debate targeting in the context of national self-reliance objectives.¹¹ Gradually, attitudes shifted from a state-centered approach for service delivery to reflect the current realities of public sector financing constraints.

The extraordinary times in Turkey called for innovative measures, and the minister of health endorsed an initiative to develop and pilot test a targeting strategy.¹² Senior managers in the MCH-FP Directorate decided to test an “ability-to-pay” strategy that would allow all family planning clients continued unrestricted access to services but would distinguish between those able to pay and those deemed too poor to pay for their family planning products and services. The critical feature of the strategy was an operational mechanism for better-off clients to contribute to the costs of their contraceptives without violating legal proscriptions regarding user fees for public services, to subsidize contraceptive supplies to the poor without turning away nonpoor clients. Therefore, clients seeking contraceptives from public sector outlets would be asked to make a voluntary donation to the HSAF for supplies to cover a portion of the cost of the foundation’s commodities, and those who declared themselves unable or unwilling to make a donation would be presumed poor and receive their method free. By definition, the donation policy was voluntary and based on a self-declared willingness to pay, which provided an administratively simple and inexpensive mechanism to protect financial access for the poor. Free access to all obviated the need to define explicit target groups and limit access for public sector services by nontarget group family planning users. Furthermore, the voluntary, self-exemption mechanism put the decision to donate in clients’ hands and thus addressed the boundary of legal proscriptions against charging fees for public health services and rendered the targeting strategy politically acceptable.

The Role of Strategic Partnerships

In mid-1998, the MCH-FP director and senior staff identified the Health and Social Aid Foundation as a potential partner for implementing and testing the ability-to-pay targeting strategy. The HSAF was already involved in a long-standing partnership with MOH health centers and hospitals to surmount nonsalary recurrent budget shortfalls by collecting donations for health services from clients using the

¹¹ National Self-Reliance Workshop, December 1995; Public-Private Partnership Workshop, May 1997; KIDOG visits Turkish President Demirel, August 1998; government meetings define targeting strategy, August 1998; HSAF meeting, 1999; national self-reliance dialogue meeting, September 1999; national policy dialogue meeting, June 2001.

¹² Letter written by the Minister of Health referring to decisions made at the stakeholders’ meeting to initiate pilot study, November 1999.

facilities. Family planning services, with the exception of IUD insertion, had been exempt from the donation scheme (POLICY Project, 1999b). The HSAF used donation revenues to support some operating costs and quality improvements at the facilities where it collected contributions.

The MCH-FP Directorate's identification of a willing partner to pilot test the ability-to-pay targeting strategy, whereby donations would be solicited from nonpoor, public sector family planning clients, was not sufficient to eliminate the political and philosophic skepticism surrounding the strategy. Therefore, the MCH-FP Directorate adopted two approaches to garner greater support. First, in collaboration with the HSAF and external consultants, the MCH-FP Directorate conducted a feasibility study from late 1998 to early 1999. Based on extensive interviews with provincial health directors from a diverse range of provinces as well as on analyses of HSAF operations, the study concluded that extending the HSAF mechanism to family planning products would be feasible, that family planning clients would be willing to make donations, and that targeting had the potential for raising sufficient resources to close the expected gap in the public sector contraceptive budget (POLICY Project, 1999b). While the feasibility study made the conceptual case for targeting and generating revenue through a voluntary donation policy, some HSAF board members still embraced the notion that family planning services was a component of public health services for which the government had a special fiscal responsibility.¹³ The MCH-FP Directorate thus took a second approach to garner support. Based on the realization that HSAF board members were relatively new to the policy dialogue process on contraceptive self-reliance, the MCH-FP director and deputies convened a series of meetings to inform board members about efforts to secure public budget funds and to convince them that a self-reliance strategy built solely on increased public funding would be insufficient and unreliable regardless of the philosophic merits of the case.

Even though the MCH-FP Directorate's policy dialogue with the HSAF board of directors convinced the board to serve as a partner for pilot testing the ability-to-pay strategy, HSAF board support was not sufficient for proceeding with the pilot test. The effort required the involvement of new stakeholders, including the HSAF's provincial and local branch leaders and provincial and local health facility leaders, who were not previously part of contraceptive self-reliance discussions; these were the professionals who would be responsible for implementation.¹⁴ The MCH-FP Directorate deputies and technical staff conducted yet more policy dialogue sessions to overcome new sources of reluctance and to design workable and acceptable solutions to operational challenges at the provincial and local levels. Not surprisingly, reluctance still centered on the cost-sharing, or donation, aspect of the ability-to-pay strategy, which would for the first time distinguish between different classes of public sector family planning clients.

A looming sense of urgency about declining stocks of contraceptive supplies led USAID to appeal to the MCH-FP director to act swiftly. Further, a public sector financing crisis in 1999 reinforced the growing sense of urgency about the need to augment the public budget component of the national self-reliance strategy. Accordingly, the MCH-FP director approved and the minister of health endorsed a six-month pilot study of the targeting strategy, which was envisioned to fine-tune operational details and further demonstrate feasibility, thereby addressing lingering skepticism.

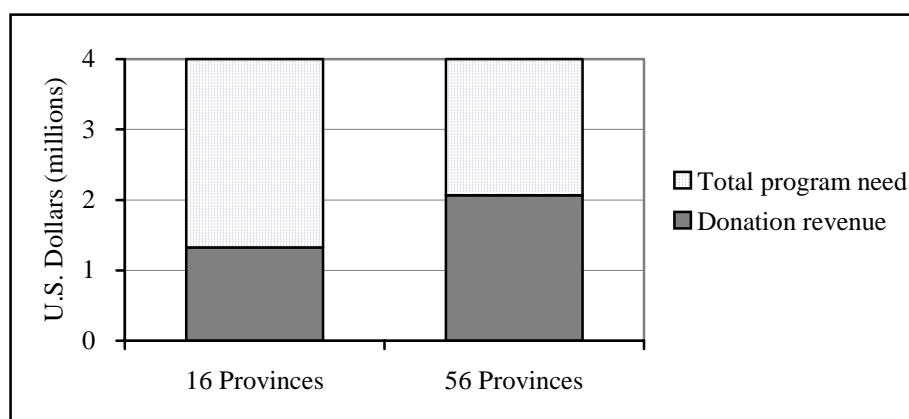
The results of the pilot study demonstrated that in principal and in practice the donation policy worked (Tatar et al., 2001). The study pointed to an apparent success all around for family planning clients, public health service providers, and the HSAF. Analysis of pilot study results showed that annual revenue potential with targeting fully implemented in 16 high-population provinces, which include more than two-thirds of Turkey's population) would reach US\$1.3 million and, if expanded to cover all 56 non-GAP provinces, would total US\$2.1 million—more than enough to close the budget gap for contraceptive

¹³ HSAF/MOH summary notes from meeting, February 1999.

¹⁴ POLICY Project records. Operational Plan of Targeting Strategy in Turkey, September 2001.

commodities (see Figure 3). National implementation of the targeting strategy would benefit clients who would continue to have access to public services either free or for a donation that cost less than commercial sector services. At the same time, family planning providers would be assured of consistent supplies, enabling them to continue providing services without interruption. MOH primary healthcare facilities would realize increased resources for discretionary use through the retained portion of donation revenues (20 percent) while HSAF branches would realize increased resources through their portion of retained donation revenues (10 percent). The MCH-FP Directorate would have sufficient resources to close the public sector funding gap. All this would occur within the bounds of Turkey's constitutional and legal framework.

Figure 3. Contraceptive Donation Revenue Projections



The success of the pilot study reinforced the MCH-FP director's resolve to establish targeting as the second pillar (the first being mobilization of budget funds) of the contraceptive self-reliance initiative. He and other senior staff used the study results to promote the idea that wide-scale implementation was the best way to maintain and possibly even expand broad access to public sector family planning services. The study's favorable outcome led to the MOH's official adoption of the targeting policy on June 20, 2001.¹⁵ Leaders and technical staff within the MCH-FP Directorate and MOH had come a long way toward changing the pervasive sense of entitlement to free family planning commodities and services.

A further test of political commitment to the new policy was expansion and implementation beyond the pilot areas. Many provincial and local officials were only remotely aware of the contraceptive self-reliance challenge facing the country and of the targeting strategy. While central-level authorities could issue directives to order implementation, support from provincial and local leaders would be required to ensure compliance and generate donation revenue. In large part, the future success of the new targeting strategy and donation policy rested at the provincial level, where the MCH-FP Directorate leaders and HSAF had to focus intensive efforts on awareness raising, establishing administrative procedures for donation collection and processing, and setting up reporting, monitoring, and evaluation systems.

In 2001, the MCH-FP Directorate staff devised an ambitious plan to expand implementation of the targeting strategy. The plan called for creating provincial training teams that would establish provincial-level ownership and commitment to implementing and monitoring the strategy.¹⁶ At the end of the 19-

¹⁵ Letter written by the Minister of Health, June 2001.

¹⁶ POLICY Project records. Ministry of Health Family Planning Program. 2001. *Design and Implementation of Expanding Donation Policy for Contraceptive Commodities*.

month first phase of the national roll-out plan, 18 of the most populous and better-off provinces (two more than originally planned) had implemented the strategy, generating approximately US\$500,000 in donation revenue. The first-phase implementation further demonstrated that the targeting strategy could close the financing gap between the national need for contraceptive supplies and the funds available from the public budget. The commitment within the MOH to the targeting strategy was strong from the minister's office down to the facility level. There was little, if any, remaining reluctance in espousing public commitment to the strategy, and the debate ceased among key stakeholders about whether or how to target family planning services.¹⁷

Summary of the Targeting Policy Component

In summary, the process of developing a targeting policy built on the groundwork laid for securing public budget funding for contraceptives. The fact that public budget allocation fell short of the national program resource needs gave way to exploring nonbudget means of closing the remaining funding gap. Targeting as a second strategy was initially met with resistance but with time, resistance lessened. The evolution towards stakeholder acceptance of targeting occurred in part because of the MCH-FP Directorate's experience in not fully succeeding with its budget strategy and in part because of its intensive, ongoing policy analysis and dialogue. Also, with the appointment of a new director came a new approach to partnerships in policy dialogue and advocacy. The MCH-FP Directorate expanded the circle of participants, both within key government ministries and beyond to academia and family planning NGOs; clearly, the bridge-building approach paid off. Incrementally broadening the participation of stakeholders spread some of the risks inherent in the reform process and nurtured increased support for the program and proposed reforms.

The strategic partnership formed between the MOH and the HSAF lies at the heart of the success in gaining official approval for the targeting policy. With the HSAF providing the operational mechanism for donation collection, the targeting policy became a win-win solution for all. National expansion of the policy had substantive potential benefits for clients; they would continue to enjoy access to public sector family planning services at a cost below commercial sector prices while there would be a safety net for the poor. The MCH-FP Directorate would have sufficient contraceptive supplies to distribute to the entire MOH healthcare delivery network, and family planning providers would continue delivering services without contraceptive supply interruption. Public healthcare facilities in affected provinces would realize increased resources for discretionary use through the retained portion of donation revenues (20 percent). At the same time, HSAF branches would realize increased resources through their portion of retained donation revenues (10 percent). Again, all this would occur within the bounds of Turkey's constitutional and legal framework.

¹⁷ POLICY Project records. Quarterly Management Report, December 2002.

Conclusions

The experience of achieving contraceptive self-reliance in Turkey demonstrates the importance of the political economy dimensions of the process. These dimensions exerted an influence on the process itself and on the outcomes that was at least equal to the influence of the strategy's technical aspects. In fact, technical information often achieved its greatest use as a tool to influence the political positions of stakeholders and their negotiations. For instance, while the pilot study served the important technical function of enabling refinement of the operational details of the targeting policy, it was also instrumental in reducing political anxieties about the policy and thereby solidifying support among public policymakers.

When analyzed from a political economy perspective, the development and implementation of the contraceptive self-reliance strategy process clearly was not linear, as may be suggested by a technical review of the process. As new stakeholders entered the process, new positions emerged and old ground had to be revisited, sometimes setting the process back, sometimes advancing it. Much of the nonlinearity of the process can be attributed to changes that could not be foreseen. The shepherds of the process—who were not always the same from the beginning to the end of the process—had to be nimble and prepared to adjust their strategies and approaches in step with an evolving environment. Changes in government brought new ministers to the heads of government agencies and translated into dramatically different political positions on family planning. New stakeholders needed to be oriented to the self-reliance challenge, and some were more supportive than others. Each change at the most senior political level, of which there were many during Turkey's transition to family planning self-reliance, affected the will of other stakeholders to take controversial stands and act on those stands, thereby generating momentum for reform. Stakeholders' positions on proposed policy options also changed as the environment around them changed, and the policy dialogue and process shifted commensurately.

Actions at critical times by policy champions such as the second MCH-FP director played a crucial role in accelerating the policy reform process. Actions on the part of the donor—the chief progenitor of the self-reliance process—also added unpredictability to the process. Just as decisions to provide supplies above agreed-upon levels, which occurred twice, inhibited government action, the unexpected announcement that condom donations would terminate two years early acted as a strong catalyst to policy action.

Clearly, the prevailing policymaking approach must be considered in mapping out a strategy to achieve a desired policy objective—in this case, policies that would promote contraceptive self-reliance. Turkey's political system best fits Grindle and Thomas's notion of a state-centered system whereby government institutions largely drive policy processes. Moreover, central government authorities dominated policymaking; provincial authorities had little access to these processes.

However, systems evolve, and over the seven-year process in Turkey (the five years of the phaseout itself and the two subsequent years needed to put in place emerging policies), the process became more inclusive. As centrally driven approaches yielded less than adequate results (e.g., in securing budget funds for contraceptive procurement), senior staff of the MCH-FP Directorate became more open to partnership with NGOs in policy advocacy. They also found that partnerships with provincial government authorities and healthcare facility managers were useful in counteracting central-level policymakers' ambivalence about targeting. It took a political leadership shift and dwindling contraceptive stocks to spur the forging of these new partnerships.

On balance, expansion of the policy dialogue circle proved instrumental in both securing budget resources and obtaining approval for the targeting policy, but such expansion required changes in approach. As a more complex array of interests came into play, policy dialogue sessions became larger and more

complex, and consensus building proved more time-consuming. Greater time and effort were required from stewards of the policy development process, and coordination and communication became increasingly crucial.

It may have been useful to have tapped the constructive power of Turkey's health sector leaders at the subnational level earlier in the self-reliance strategy development process. Similarly, if civil society, represented in this process by KIDOG, could have provided support earlier in the process, its involvement might have expedited policy development and approval. The fact that these two stakeholder groups, which turned out to provide significant impetus to change, were not involved earlier was a function of the groups' lack of preparedness to participate at that time and the government's unreadiness to allow them to do so.

Generally, the broader the base of stakeholder involvement on which policy outcomes are formulated, the greater the likelihood of the outcomes' sustainability. A broad base alone, however, might not be sufficient to ensure sustainability. In both the budget and targeting components of its self-reliance strategy, the MCH-FP Directorate faced choices about the degree of formality to seek in sanctioning its policy decisions. The Directorate sought a more formal approach as a means of improving prospects for sustainability of the strategy. As for the budget, the MCH-FP Directorate opted for a formal earmark for contraceptive procurement. The alternative of seeking an unmarked increase in a general line item would have been easier to achieve, but, in the resource-poor environment of public budgets, it would have been difficult to ensure that the funds were spent on contraceptives. Similarly, MCH-FP Directorate leaders sought formal endorsement of the targeting policy rather than pursuing a less formal and more quietly implemented agreement with the HSAF to begin collecting funds from family planning clients.

However, the donation mechanism no longer exists in Turkey because just as unpredictable events can complicate, derail, or accelerate policy change processes, so, too, can they undo the officially endorsed outcomes resulting from well-executed and broadly supported processes. Turkey's public financial crisis in 2002 led the government to seek outside support from the International Monetary Fund (IMF) for public finance relief. As part of IMF's broader investigation of how public sector organizations are funded, the long-standing and widely used foundation mechanism of collecting donations from clients and using funds to augment operating budgets came under scrutiny. Because the donation mechanism operates outside of formal public sector financing mechanisms, it is less transparent and more difficult to oversee. As such, the IMF and the government determined that the donation strategy did not fit well with longer-terms goals of putting public finances on a more solid footing, and about a year after completion of scale-up to 18 provinces, Turkey withdrew official approval for the donation mechanism as a means of generating resources for public budget needs, demonstrating that, in policy processes, there are no guarantees.

Despite this seeming setback, it is encouraging to note that MCH-FP Directorate leaders were successful in securing sufficient additional resources from the central treasury that same year to fill the new funding gap for contraceptive supplies. The ease with which the leaders made the case contrasts sharply with the previous difficulties that necessitated development of the targeting component of the national self-reliance strategy. It attests to the effectiveness with which the policy dialogue and change process changed perspectives about the importance of family planning in Turkey and bodes well for the longer-term security of the national program.

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